Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: TWELVE OAKS MEDICAL CENTER PO BOX 676855 DALLAS TX 75267	MFDR Tracking #:	M4-03-7553-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: Transcontinental Insurance Co. Box #: 47	Date of Injury:	
	Employer Name	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Claim paid incorrectly Should have paid at 75 percent of total charges. Paid at 6 percent" [sic]

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $234.00
3. Hospital Bill

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Provider billed Carrier $23,303.75 for facility services associated with the procedure. Carrier reimbursed Provider $1,397"… "This amount was calculated using Carrier's outpatient methodology and represents base reimbursement of $1,100 plus additional reimbursement of $297 for implants billed under revenue code 278."… "the provider incorrectly billed this admission as an outpatient admission when in fact this was an inpatient admission."… "According to the Provider's UB-92, the Claimant was admitted on October 10, 2002 at 1700 hours (see boxes 17 and 18) and the claimant was discharged on October 11, 2002 at 1800 hours (see boxes 6 and 21). Therefore the claimant's stay exceeded 23 hours and would be considered an inpatient admission, meaning the inpatient fee guideline applies to this case to determine reimbursement. Under the inpatient hospital fee guideline, Provider is entitled to reimbursement at the surgical per diem rate for one day plus reimbursement for the implants. Provider has already been paid this amount."… "Although this was an inpatient admission, the Provider did not bill this case as an inpatient admission by using the revenue codes for an acute care medical/surgical stay which include 111, 121, 131, 141, or 151. Because the admission was not billed properly, Carrier processed the bill as an outpatient admission using its outpatient methodology"… "However, even if the admission were treated as an outpatient admission, Provider has already been reimbursed a fair and reasonable amount and is not entitled to additional reimbursement.'… "In summary, the Commission's *per diem* rate for surgical procedures performed on an inpatient bases establishes that reimbursement at the same rate meets the Act's criteria for payment of facility services for surgical procedures performed on an outpatient basis."… "In conclusion, this was an inpatient admission for which the inpatient hospital fee guideline is applicable. Provider has already been paid the amount allowed under the guideline. However, even if this case qualified as an outpatient admission, Provider has already been reimbursed a fair and reasonable amount and is not entitled to additional reimbursement. Specifically, Carrier's rate of reimbursement in this case meets the Act's criteria for payment in all respects. Provider has the burden of proof in this case."… "The Provider has simply not met its burden of proof under rule 133.307(g)(3)(D) to establish that reimbursement of 75% of its billed charges of $23,303.75 meets the Act's statutory standards for reimbursement of its facility charges."…

Principle Documentation:

1. Response Package
2. EOB

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
6/10/2002-6/11/2002	D	Outpatient Surgery	$234.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - D – "Duplicate Bill"

   No other explanations of benefits were submitted by either party for review.
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011"…
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. The respondent's position statement asserts that "the provider incorrectly billed this admission as an outpatient admission when in fact this was an inpatient admission."… "According to the Provider's UB-92, the Claimant was admitted on October 10, 2002 at 1700 hours (see boxes 17 and 18) and the claimant was discharged on October 11, 2002 at 1800 hours (see boxes 6 and 21). Therefore the claimant's stay exceeded 23 hours and would be considered an inpatient admission, meaning the inpatient fee guideline applies to this case to determine reimbursement."… "Although this was an inpatient admission, the Provider did not bill this case as an inpatient admission by using the revenue codes for an acute care medical/surgical stay which include 111, 121, 131, 141, or 151. Because the admission was not billed properly, Carrier processed the bill as an outpatient admission using its outpatient methodology"… Per Division rule at 28 TAC §133.307(j)(2) effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, the response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review.
5. Division Rule at 28 TAC §133.307(e)(2)(B), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB)"… "relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB". This request for medical fee dispute resolution was received by the Division on May 1, 2003. Review of the documentation submitted by the requestor finds that the request does not include any EOBs for the disputed services. The requestor has included a copy of the carrier's check and check stub for payment of the services, but the Division notes that this document is not an explanation of benefits. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has failed to submit the request in the form, format and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(e)(2)(B).
6. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission". The Division notes that the requestor has listed an amount of $234.00 as the total amount billed and an amount of $234.00 as the total amount in dispute. Review of the *Table of Disputed Services* finds that the requestor has not listed the total amount paid in the appropriate column as required by Division instructions. The requestor has therefore failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(e)(2)(C).
7. Division rule at 28 TAC §133.307(g)(3)(A), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including "documentation of the request for and response to reconsideration (when a provider is requesting dispute resolution on a carrier reduction or denial of a medical bill) or, if the carrier failed to respond to the request for reconsideration, convincing evidence of the carrier's receipt of that request" This request for medical fee dispute resolution was received by the Division on May 1, 2003. Pursuant to §133.307(g)(3), the Division notified the requestor on June 23, 2003 to send the additional required documentation. Review of the submitted evidence finds that the requestor has not provided

documentation of the insurance carrier's response to the request for reconsideration or convincing evidence of the carrier's receipt of that request. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(A).

8. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records"… This request for medical fee dispute resolution was received by the Division on May 1, 2003. Pursuant to §133.307(g)(3), the Division notified the requestor on June 23, 2003 to send the additional required documentation. Review of the submitted evidence finds that the requestor has not sent a copy of any pertinent medical records. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(B).

9. Division rule at 28 TAC §133.307(g)(3)(C), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including "a statement of the disputed issue(s) that shall include: (i) a description of the healthcare for which payment is in dispute, (ii) the requestor's reasoning for why the disputed fees should be paid or refunded, (iii) how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue. This request for medical fee dispute resolution was received by the Division on May 1, 2003. Pursuant to §133.307(g)(3), the Division notified the requestor on June 23, 2003 to send the additional required documentation. Review of the submitted documentation finds that the requestor did not state its reasoning for why the disputed services should be paid; or how the Texas Labor Code and Division rules impact the disputed fee issues; or how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C).

10. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement"… The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "Claim paid incorrectly Should have paid at 75 percent of total charges. Paid at 6 percent" [sic] Review of the submitted documentation finds that the requestor did not submit evidence to support its assertion that the claim should have paid at 75 percent of total charges. The requestor did not discuss or demonstrate how it determined that payment of 75% of the total charges would result in a fair and reasonable reimbursement. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. Additionally, the Division has determined that a methodology based on a percentage of billed charges does not, in itself, produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the *Acute Care Inpatient Hospital Fee Guideline* which states at 22 *Texas Register* 6276 (July 4, 1997) that "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources." Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment in the amount of 75% of the billed charges would be a fair and reasonable rate of reimbursement for the services in dispute. Therefore, reimbursement in the amount of 75% of the provider's billed charges cannot be recommended. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.

11. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code sections §133.307(e)(2)(B), §133.307(e)(2)(C), §133.307(g)(3)(A), §133.307(g)(3)(B), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.